Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	IL6007496		10/24/2017

NAME OF PROVIDER OR SUPPLIER: COLLINSVILLE REHABILITATION & HEALTH C

STREET ADDRESS, CITY, STATE, ZIP CODE: 614 NORTH SUMMIT, COLLINSVILLE, IL 62234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 1 of 3 violations 300.610a) 300.1030a)1)2) 300.1035a) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility failed to initiate Cardio Pulmonary Resuscitation	S9999		

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S9999	Continued From page 2 (CPR) for 1 of 15 residents (R15) reviewed for Advanced Directives/CPR in the sample of 15. Facility staff failed to follow R15's Advanced Directives by not initiating CPR for R15, who subsequently expired. This failure had the potential to affect 52 of 65 residents (R1-R8, R13, R18-R47, and R49-R61) whose Advance Directives indicate Full Code Status. On 6/30/17, the Regional Nurse and Social Service Director completed an initial audit of resident medical records for current status of advance directives related to code status, POLST, living will, POA-health care, POA-finance, health Care Surrogate and Guardianship. On this day, the Social Service Director initiated clarification of resident code status discrepancies identified during the audit of advance directives related to completion of POLST. The Regional Nurse audited facility nursing personnel related to CPR certification. The Administrator contacted CPR instructor to schedule classes for facility staff certification. On 7/1/17, the Social Service Director continued clarification of resident code status discrepancies identified during the audit of advance directives related to completion of POLST. The Regional Nurse conducted random chart reviews for physician and family notification. On 7/3/17, the Regional Nurse completed 100% staff in-servicing for all departments including Administration, Nursing, Housekeeping/Laundry, Dietary, and Maintenance regarding facility policy related to Physician and Family Notification, Nursing Assessment, Advance Directives, POLST, and CPR including staff certification	S9999		

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S9999	Continued From page 3 requirements and when to initiate CPR. On this day, The Regional Nurse clarified with all staff during 100% inservice that "identification" of resident code status is located in each resident's medical record under the Advance Directive tab on the POLST form. If there is no POLST form, resident remains a full code. The Regional Nurse conducted random chart reviews for physician and family notification. The Regional Director, Regional Nurse, and Social Service Director re-audited each resident medical record for current status of advance directives related to code status including proper completion of POLST, cross referencing Face Sheet, Physician Order Sheet and Care Plan. Findings Include: The Facility's Cardiopulmonary Resuscitation Policy, revised on 6/5/13, documented "It is the policy of (Facility) that cardiopulmonary resuscitation (CPR) shall be initiated and maintained by qualified staff, in cases of recognized cardiac and/or pulmonary arrest to sustain or support a resident's cardiac and/or pulmonary function until advanced life support systems are available. Cardiopulmonary resuscitation shall be initiated on all residents except those who have designated through advanced directives and/or have a specific physician order for 'DNR', "No Code,' or "no CPR'. Nursing personnel of this facility shall be certified in CPR within a reasonable time after hire and annual thereafter." The Policy documented the following procedure should be directed by a licensed nurse in the event of cardiac distress:"1. Assess for cardiac distress; 2. Assess resident status (vital signs, color, consciousness, responsiveness) treat as	S9999		

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indicated. Initiate oxygen at 6 liters per minute for any of the above symptoms; 3. Call emergency rescue services unless resident is of NO Code status. If 'No Code' status, notify physician and proceed as ordered; 4. Place on a hard surface; 5. Initiate Artificial circulation/chest compression if pulse is absent; 6. Initiated artificial respirations if respirations are non existent or cease; Continue CPR until: a. Advanced life support systems are available, operable and resume care b. The resident responds, c. A physician orders CPR to be discontinued; 8. Document all observations and occurrences in the medical record."

The Facility's Do Not Resuscitate Policy, dated 11/11/13, documents it is their policy that CPR and other emergency procedures will be initiated in all circumstances of a resident cardiac or pulmonary arrest unless a valid Do Not Attempt Resuscitate (DNR) order is written in the resident's record.

R15's Physician Order Sheet (POS), dated 06/01/17, documents R15 has diagnoses of Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Anxiety, Depression, Osteoporosis, and Low Back Pain. R15's POS, dated 03/13/17, documents R15 is a Full Code.

R15's Nurse's Notes, dated 06/30/17, documents, "resident (R15) time of death is 4:45 PM determined by writer (E25, Former Facility Licensed Practical Nurse, LPN), and (E7, LPN) other staff nurse verified by no pulse, no heart beat, and no respirations, 5:00 PM (Z2, Physician) and Coroner was notified. At 5:25 PM the local funeral home was notified to pick up the body. At 6:45 PM the local funeral home here to pick up the remains. (R15's) son in law was at her

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S9999	Continued From page 5 bedside." R15's State of Illinois Certificate of Death Worksheet, dated 07/05/27, documents R15's date of death as June 30, 2017. The form also documents her cause of death Coronary Artery Disease, Acute Myocardial Infarction, and Hypertension. The Facility's Untitled time line form, dated 06/30/17, documents (in part) at 2:35 PM, R15 was greeted by E12, Certified Nursing Assistant (CNA), at 3:30 PM, E16, CNA, toileted R15, at 3:45 PM, R15 in the television room, at 4:33 PM, R15 in her room watching television, at 4:40 PM, R15 was found slumped in her chair, and at 4:45 PM, per nursing notes resident's time of death. The Facility's Incident Report Form/Illinois Department Public Health Notification, dated 7/1/17, documents allegation of neglect. Nurse immediately suspended, investigation initiated per protocol, and the type of incident as inappropriate action by staff. A Facility Letter to Illinois Department of Public Health, dated 07/10/2017, documents (in part) "please accept this letter as the final report to the initial notification submitted on 07/01/17 regarding an allegation of neglect involving (R15) and (E25). During the investigation it was noted that approximately 4:40 PM on 06/30/17 (R15) was found unresponsive. The staff members notified (E25) LPN of the residents change of condition and report that (E25) failed to thoroughly assess (R15). (E25) was interviewed, and she made a visual assessment of her condition. (E25) reports that a second nurse (E7, LPN) assisted with assessment of the resident's condition. However the second nurse (E7) denied assessment of the	S9999		

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resident. In conclusion the facility was able to substantiate the allegation and (E25) was terminated from her position."

E26, former CNA, untitled employee statement, dated 06/30/17, documents E26 stated that she was working the 300 hall, helping residents to the dining room. At approximately 4:40 PM, she walked into R15's room, and saw R15's chair facing away from the television. E26 asked R15 if she needed assistance, but no reply from R15. E26 walked closer to R15, and noticed her lips and chin area were purplish in color. E26 called for another CNA, because R15 was not breathing. E26 tried to arouse R15 several times. Other CNA's went into the room. E26 heard a stat page to R15's room. E25 entered the doorway of R15's room, and stated "Oh not (R15)." E26 stated that E25 stated R15 is a full code. E25 left the room, and E26 didn't see E25 assess R15. E26 stated that after R15 had been transferred to the bed, E26 continued her regular duties of passing meal trays. E26 saw E25 sitting at the 300 hall nurses desk.

E16, CNA, untitled employee statement, dated 06/30/17, from the facility investigation dated 6/30/17, documents E16 was assigned to R15. R15 was assisted to the bathroom by E16. R15 asked to be laid down, but E16 suggested that she go watch television until dinner. R15 was rolled to the dining area by E16. E16 continued her work assignment until 4:45 PM, when E26, CNA, told her R15 had died. E16 went to R15's room and saw E25 in the hallway, while E16 was in R15's room E16 did not see a nurse in the room.

E12, CNA, untitled employee statement, dated 06/30/17, documents E12 didn't have any other

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interaction with R15 until approximately 4:42 PM when another CNA told her R15 had passed away. E12 went to R15's room, and she noticed that R15 was slumped in her chair and her lips were blue. E12 noticed E25 in the doorway, but she did not notice E25 enter the room. E12 stated she heard E25 state that R15 was a full code. E25 also told them to clean R15 up and put a gown on her.

E13, CNA, untitled employee statement, dated 06/30/17, documents E13 and E15, CNA, were in the 200 hallway, when E13 heard the stat page to R15's room. E13 went into the room. Several CNA's were in the room. E25 was in the doorway. E13 heard E25 state put R15 to bed. E13 assisted with putting R15 to bed. E25 returned to her other duties, and E13 observed E25 sitting at the desk making a telephone call.

E18, CNA, untitled employee statement, dated 06/30/17, documents E18 heard the over head page to room R15's room. E18 told the other CNA's to transfer R15 to bed. R15's face color was changing to a bluish color. E18 asked E25 if R15 was a full code. E25 did not respond, and E25 left the room. E18 overheard E25 ask for the number to the morgue.

E7, LPN, untitled employee statement, dated 06/30/17, documents that E7 was on the 200 hall when a CNA notified E7 that she couldn't find the 300 hall nurse, and that R15 had passed away. E7 walked to the 300 hallway and saw E25 leaving the room, and closed the door behind her. E7 asked E25 if there was anything she could do, E25 asked her for paperwork. E7 went back to 200 hall. E25 called E7 wanting the telephone number to the coroner. E7 then went to 300 hall desk, and asked E25 if R15 was a full code. E7

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S9999	Continued From page 8 looked at the list, and stated R15 is a full code. E7 then stated E25 stated, 'Oh my God, I don't know what to do.' E14, CNA, untitled employee statement, dated 06/30/17, documents E14 was in the dining room passing meal trays. A CNA ran into the dining room and stated R15 is dead. E15 and the other CNA went to R15's room, and R15 was slumped in her chair. E14 ran to the phone and paged E25. E14 went back to R15's room. E25 entered the room 3 to 5 minutes later. E14 said E25 stated R15 was a full code. E14 stated E25 left the room and didn't return. On 10/17/17 at 3:44 PM in a telephone interview, E25 stated, "I decline to be interviewed. I would rather not speak on it." On 10/17/17 at 3:35 PM, E9, LPN, stated regarding what she expects the CNA's to do when they find an unresponsive resident, "They (the CNA's) should get the nurse, and take their vitals, see if they are a full code, and start CPR." E14, CNA, on 10/17/17 at 3:25 PM, stated, "I was in the dining room and one of the CNA's (E12) ran into the dining room looking for the nurse. We ran to the room, and (E15) was already in the room. We asked (E25) what to do, and she said put her into bed. I left the room to complete serving. We had an inservice on CPR therapy, but most of the CNA's were not CPR certified. We had a class on 08/02/17." E15, CNA, on 10/17/17 at 3:10 PM, stated, "I know it happened fast. I went to the room (R15's) mouth was blue black, and she was slumped over in her chair. I stayed in the room while everyone else went to get the nurse. I thought	S9999		

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S9999	Continued From page 9 only the nurse could do CPR. The nurse just said laid her down. No one did CPR." E12, CNA, on 10/17/17 at 3:05 PM, stated, "It was 4 PM, I was getting residents up for dinner. Me and (E14) were on break. We went to (R15's) room (E25) told us to lay (R15) down. (R15) made a gasping noise when we laid her down, and no one did CPR. We should start CPR, after the nurse is notified." E17, CNA, on 10/17/17 at 3:15 PM, stated "I know (E14) made a call for everyone to get to (R15's room). (R15) was sitting in her chair. (E25) stood by the door, and asked (E14) to clean (R15) up. I wasn't CPR certified, and no one did CPR. I took a class myself outside of the facility. The nurse tells us what to do, check the book to see if they need CPR, and the other person puts the slide board under the patient." E19, CNA, on 10/17/17 at 3:20 PM, stated, "I wasn't here the night it happened. I was inserviced on CPR. We get the nurse. I was CPR certified. I would go get the nurse crash cart, and then do CPR." E1, Administrator, on 10/18/17 at 8:11 AM, stated, "The staff should look in the chart. Its color coded red or green. The red form is for stop, and the green one is for full code. The white form in the chart is the original. Yes, I expect the CNA's to do CPR under the direction of the nurse." E2, Director of Nursing, on 10/18/17 at 8:00 AM, stated, "The staff should get the charge nurse. They should try not to leave the resident alone, but do emergency care. Start CPR after check positioning. I want the nurse to assess them. If	S9999		

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S9999	Continued From page 10 deemed necessary, start oxygen, get the crash cart, and call 911." Z2, Physician, on 10/18/17 at 8:00 AM, stated, "If the resident is a full code, the facility should do CPR." The Facility provided an undated resident roster with Full Code written at the top with residents highlighted in yellow that are a full code. This list included R1-R8, R13, R18-R47, and R49-R61. On 8/21/17, a Quality Assessment Meeting was held with Department Heads at facility, Medical Director and Pharmacist. On 7/22/17, the facility had a full code occurrence and through QAPI process and removal plans, staff were fully compliant as evidenced by adherence to established policies and procedures related to Advance Directives and CPR. The Meeting concluded that through QAPI and Removal Plan the facility was effective in attaining compliance with this issue. On 10/19/17, an Immediate Jeopardy was identified. E1, Administrator, and E2, Director of Nurse's, were notified of the Immediately Jeopardy Past Noncompliance on 10/19/17 at 10:21 AM. The Past Non Compliance began on 6/30/17 when the facility failed to initiate CPR for R15 who was a full code status. R15 subsequently expired. On 9/24/17, the surveyors determined through observation, interview and record review, the facility took the following actions: 1. On 6/30/17, the Regional Nurse and Social Service Director completed an initial audit of resident medical records for current status of	S9999		

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S9999	Continued From page 11 advance directives related to code status, POLST, living will, POA-health care, POA-finance, health Care Surrogate and Guardianship. On this day, the Social Service Director initiated clarification of resident code status discrepancies identified during the audit of advance directives related to completion of POLST. The Regional Nurse audited facility nursing personnel related to CPR certification. The Administrator contacted CPR instructor to schedule classes for facility staff certification. 2. On 7/1/17, the Social Service Director continued clarification of resident code status discrepancies identified during the audit of advance directives related to completion of POLST. The Regional Nurse conducted random chart reviews for physician and family notification. 3. On 7/3/17, the Regional Nurse completed 100% staff in-servicing for all departments including Administration, Nursing, Housekeeping/Laundry, Dietary, and Maintenance regarding facility policy related to Physician and Family Notification, Nursing Assessment, Advance Directives, POLST, and CPR including staff certification requirement s and when to initiate CPR. On this day, The Regional Nurse clarified with all staff during 100% inservice that "identification' of resident code status is located in each resident's medical record under the Advance Directive tab on the POLST form. If there is no POLST form, resident remains a full code. The Regional Nurse conducted random chart reviews for physician and family notification. The Regional Director, Regional Nurse, and Social Service Director re-audited each resident medical record for current status of advance directives related to code status including proper completion of POLST, cross	S9999		

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	referencing Face Sheet, Physician Order Sheet and Car Plan. (A) 300.610a) 300.1010h) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the			

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STREET ADDRESS, CITY, STATE, ZIP CODE: 614 NORTH SUMMIT, COLLINSVILLE, IL 62234

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S9999	Continued From page 13 health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 14 These Requirements are not met as evidenced by: A. Based on interview, observations and record review, the facility failed to provide necessary care and services and timely identify and assess/monitor a significant change in health condition for one of 3 residents (R14) reviewed for necessary care and services in a sample of 15. This resulted in hospitalization for R14 when she went unresponsive. R14 was admitted to the hospital with sepsis, hypercapnia, acute respiratory failure, lactic acidosis and hypotension. Findings include: 1. The Minimum Data Set (MDS) dated 8/2/17 documents R14 to be cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15. The MDS documents R14 to be independent in transfers, and mobility about the room at the time of the assessment along with R14 to be "occasionally incontinent." R14's Urinalysis with culture, dated 9/19/17, documented R14 had a urinary tract infection (UTI) which cultured >100,000 CFU (colony forming units) of Escherichia Coli and R14 was placed on Ciprofloxacin. (Cipro). R14's Telephone Orders, dated 9/22/17, documented Cipro was discontinued and Augmentin 875 milligrams twice daily for ten days was started. R14's Nurse's Note, dated 9/23/17, at 5:00 AM documented "no (change) noted. ABT (antibiotic) therapy started," The Nurse's Note documented	S9999		

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S9999	Continued From page 15 "no discomfort or pain when asked" and "tolerating fluids well. Will cont (continue) to monitor." The next entry is at 10:30am and document "denied pain/discomfort @ (at) this time. pt (patient) is afebrile 97 PO (by mouth) fluids encouraged Resp (respirations) even unlabored. Will cont to monitor." R14's Nurse's Note, dated 9/24/17 at 1330, written by E9, Licensed Practical Nurse (LPN), documented R14's temperature still afebrile with no adverse effects, fluids encouraged, c/o burning when urinates, excoriated skin. R14's Nurse's Note, dated 9/25/17, written by E7 (LPN) documented at 1400 (2pm) that R14 "denies discomfort, is afebrile, PO fluids encouraged, is able to make needs known." R14's Nurse's Notes for 9/26/17 at 2:00 PM and 10:00 PM documented R14 had no complaints of pain and/or discomfort and fluids were encouraged. R14's Nurse's Note for 9/27/17 (no time), written by E9, documented R14's temperature was 98.1 degrees with no adverse reactions and "fluids encouraged." At 10:15am, the NN document "cont ABT for UTI s (without) adverse effects." R14's Nurse's Note, dated 9/28/17, at 10:40 PM documented "remains on ABT for UTI. No adverse reactions noted. Voices no concern." R14's Nurse's Note, dated 9/29/17 at 11:10 AM, written by E7 Licensed Practical Nurse (LPN) documents "Res (resident) to be seen in the ER (Emergency Room) r/t (related to) AMS and possible dehydration. TO (Z2 - Medical Director.)" The Resident Transfer Form dated 9/29/17	S9999		

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S9999	Continued From page 16 documents the reason for transfer is "not eating or drinking, c/o (complains of) pain all over her body" and "refusing to eat or drink." The Emergency Medical Services (EMS) report dated 9/29/17 documented R14's Oxygen saturation was 72% on 3 Liters (L) of oxygen by nasal cannula. Hospital Emergency Department (ED) notes dated 9/29/17 documents R14 presented to the hospital unresponsive and was intubated for ventilator use. The ED Report dated 9/29/17 documents "Pt (patient) is a 68 y/o (year old) female who presents to the ED, via EMS, c (with) c/o unresponsiveness" and "Per EMS report, they were called to the facility today due to the pt being unresponsive and having an SaO2 in the 70's. Upon EMS arrival, they placed a CPAP machine on the pt, which brought her SaO2 up into the 80's. Pt began to respond to pain only en route to the ED." The Hospital History and Physical dated 9/29/17 documented "The patient was admitted to the intensive care unit with sepsis, hypercapnia, acute respiratory failure, lactic acidosis and hypotension." The History and Physical Assessment and Plan documented "Acute Respiratory Failure, Questionable for a UTI, Diabetic Ketoacidosis with metabolic acidosis, Hypotension secondary to sepsis, and acute renal failure." On 10/11/17 at 2:12 PM, E9 (LPN) stated R14 had been getting more confused and lethargic, "something different about her" in the week prior to her transfer. E9 stated R14 would usually get up early in the morning and then started to get up by noon. E9 stated she would also say "off the	S9999		

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S9999	Continued From page 17 wall things" but couldn't recall anything specific except that R14 would look for things that were right in front of her, and turn her light on when she couldn't find it. E9 stated this began to occur on 9/27 and 9/28/17. E9 stated R14 wasn't eating as well either and it was taking her longer to do things than it normally did. E9 stated she thought it was just the UTI. E9 stated she had come in early on 9/29/17 and E7 LPN called her to R14's room. E9 stated when she went to R14's room that morning, R14 hadn't touched her breakfast yet and they couldn't get her to wake up for her medications. E9 stated R14 was not responding to voice commands but would moan when moved. E9 stated R14 also had trouble transferring herself the last few days and had therapy look at her. E9 stated R14 went from transferring herself to a full body mechanical lift in the last few days. E9 stated she didn't think it was a condition change just due to her having a UTI. On 10/11/17 at 12:40 PM, E3, Registered Nurse (RN), stated R14 was alert and oriented until the last few days adding that she used to come to the dining room for all three meals but did not do so the last couple of days she was here. On 10/8/17 at 9:55 AM, E7 (LPN) also stated R14 had been declining in the days prior to her hospitalization with no longer transferring herself, being a full body mechanical lift, no longer went to the dining room for breakfast, and was mostly incontinent. E7 stated on 9/26/17 she first noted that R14 didn't eat her breakfast when she went in to give her medications that morning. E7 stated she hadn't touched her coffee and refused to take her medications saying she was "too tired." E7 stated when they first notified the EMS, they told them it wasn't an emergency, "no lights, no sirens", but as they waited, R14 became	S9999		

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unresponsive and they called EMS back to get them there sooner. E7 stated the first time she took R14's oxygen Saturations it was low 90's and the second time, dropped into the upper 80's. E7 didn't recall it being in the 70's as reported in the EMS report. E7 stated she started Oxygen at 3 L per a nasal cannula and waited for the EMS to arrive.

On 10/11/17 at 12:50 PM, E2, Interim Director of Nurse (DON)/Registered Nurse (RN) stated R14 was alert and oriented times three but understood that she was a little confused the last few days needing more help.

On 10/18/17 at 12:55 PM, Z2, Primary Physician stated he would have wanted to know if R14 had exhibited an overall decline in mobility and cognition in the days prior to her becoming unresponsive as he would have done something sooner. When told the nurses repeatedly documented "no adverse effects" in the NN but acknowledged in interview that R14 had an overall decline, Z2 stated "They should write what they see" and let him know. Z2 stated he didn't recall being told about the decline when he saw her on 9/25/17 for her monthly visit.

A physician note dated 9/25/17 confirms R14 was seen by E2, Primary physician for a monthly visit with no abnormalities identified by the nurses to Z2 in terms of the changes/decline in R14's functional and cognitive abilities.

The facility's policy/procedure entitled "Notification for Change in Resident Condition or Status" dated 8/1/12 documents it is the policy of the facility to "promptly notify appropriate individuals (i.e., Administrator, DON , Physician, Guardian, HCPOA, etc) of changes in the

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S9999	Continued From page 19 resident's medical/mental condition and/or status." The Nurse Supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident by the residents next of kin or representative when the resident has any of the afore mentioned situations. B. Based on observation, record review, and interview, the facility failed to provide necessary care, services and treat venous ulcers and skin conditions for two of two residents (R8 and R14) reviewed for wounds/skin conditions in the sample of 15. Findings include: 2. R14's Minimum Data Set, dated 8/2/17 documented R14 to be cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15. The MDS documented R14 to require extensive assist for bathing and "occasionally incontinent." R14's Physician Order dated 9/14/17 documented an "antifungal cream to peri area/buttocks every shift and as needed." R14's September 2017 Treatment Administration Record (TAR) documented the Antifungal cream as of 9/14/17. The TAR has blanks as the treatment not being done for the 6pm to 6am shift on 9/18, 9/19, 9/25 and 9/28/17. R14's September 2017 TAR Weekly Summary, dated 9/19/17 documented "continue c (with) fungal rash to periarea/bottom O (no) open areas. Scabs to RFA (right forearm.)" There were no measurements or any other information regarding the fungal rash being treated.	S9999		

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S9999	Continued From page 20 The next entry into the TAR regarding R14's rash was dated 9/27/17 and documents "cont (continue) c antifungal cream to buttocks. o (no) open areas." R14's Nurse's Notes, dated 9/29/17, at 11:10 AM document R14 being transferred to the hospital for an overall condition change. R14's Hospital History and Physical notes dated 9/29/17 document R14 to have possible cellulitis to her left buttock. The Note documented "She has an abrasion to her right buttocks and she has an area around the peri-rectal area, and she also has an abrasion under left buttock, which is red and swollen." On 10/11/17 at 2:12 PM, E9, Licensed Practical Nurse (LPN) stated R14 had a rash on her bottom,"big red splotchy rash" which she had been getting Diflucan and a medicated cream for. E9 stated "at first, it was the whole peri area and buttocks, but cleared up then came back with the Nurse Practioner giving the order on 9/14/17. On 10/18/17 at 9:55 AM, E7 (LPN) stated R14's rash started out just on her labias and was red and inflamed. E7 stated she didn't have any redness on her "back side" or rectal/buttocks area. On 10/17/17, the facility provided a "Decubitus Care/Pressure Areas" policy/procedure when asked for a wound and/or skin issue policy. The policy dated 5/07 documents the documentation of a new pressure area must occur upon identification and at least once a week on the TAR. The assessment must include: Characteristics (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue,	S9999		

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	etc.)			
	(A)			
	300.686b)			
	Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs			
	b) Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106.1(b) of the Act) Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome. Side effects of the medications shall be described.			
	This requirement is NOT MET as evidenced by:			
	Based on interview and record review, the facility failed to obtain consent for the use of psychotropic medications for 3 of 8 residents (R1, R6 and R11), reviewed for psychotropic medication use in the sample of 15 and 1 resident (R26) in the supplemental sample.			
	Findings include:			
	26's Minimum Data Set (MDS) section D0200			

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S9999	Continued From page 22 dated 8/10/17 documents 7-11 days out of 14 days of feeling down, depressed, or hopeless. R26's Physician Order Sheet (POS) dated 10/17 documents a diagnosis in part of acute psychosis, depression, schizophrenia, and paranoia. R26's Psychotropic Medication Consent-Antipsychotic dated 02/16/15 documents consent for medication Latuda 80 mg at bedtime. R26's POS dated 10/17 documents Latuda 120mg by mouth every evening. On 10/19/17 at 3:30PM, E7, Licensed Practical Nurse (LPN) stated in part, "The nurse is responsible for getting the consents." 2. R1's Physician Order Sheet (POS) dated 10/01/17 documents R1's diagnoses in part, of schizophrenia Paranoid Type, Psychosis, and Dementia. R1's POS, dated 10/01/17, documents R1's is on Depakote 500 milligrams (mg) twice daily (bid), Haldol 5mg two tablets four times daily (qid), Sertraline 75mg daily (qd), Tegretol 400mg bid, Ativan 2mg bid, Abilify 30mg qd and Seroquel 50mg every four hours when necessary. On 10/19/17 R1's Clinical Record did not document any consents authorizing R1's use of her psychotropic medications listed above. 3. R6's Mid-America Psychiatric Consultants progress note dated 03/13/17 documents "Patient reports hears voices yelling, but not commanding. Diagnosis: Bipolar/ Schizoaffective Disorder." Plan: Increase Prolixin 5 milligrams three times a day. R6's most recent Minimum Data Set (MDS) dated 08/20/17, Section E. (E0100) Potential indicators of Psychosis is checked A. Hallucinations (perceptual experiences in the	S9999		

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S9999	Continued From page 23 absence of real external sensory stimuli) Additional Diagnosis, listed within the MDS Section I. Include Heart Failure, Depression, Manic Depression, Cardiomyopathy and Presence of Pacemaker. On 10/19/17 at 9:10AM, E2 Acting Director of Nurses (ADON) stated "There was no, informed consent within R6's record for the psychotropic medication Prolixin, that indicates the possible side effects or the benefits of reduction of symptoms, possible participation or interest in Activity of Daily Living (ADL's). On 10/19/17 at 11:00AM, E2 stated "R6 is on a home visit today, so E2 received telephone consent for the Prolixin." The facility's Psychotropic Medication Policy revised 12/30/13 documents: Procedure: #4: Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. (AW)	S9999		